STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/23/11 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/22/11 Facility Number: 000389 Provider Number: 15E245 AIM Number: 100288920 Surveyor: Mark Caraher, Life Safety Code Specialist At this PSR survey, St. Augustine Home for the Aged was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, located on the second and third floor of a three story building was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 42 and had a census of 40 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0011 SS=E	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 Based on observation and interview, the facility failed to ensure 4 of 4 door sets in the fire barrier separating health care from the assisted living occupancy provided the protection needed for a two hour fire barrier. LSC 19.1.1.4.2 refers to LSC 8.2. LSC 8.2.3.2.3.1 requires openings in a 2 hour fire barrier be provided with doors having at least a 1 1/2 hour fire protection rating. This deficient practice could affect residents, staff and visitors in the vicinity of the second and third floor dining room Center Stairwell access doors and the	K0011	We are enclosing a copy of a contract that we have with Koorsen's Fire and Security that shows it is the Corporate Board's decision to put smoke detectors in all areas eliminating the need for fire barrier doors since this would then enlarge the area having the exterior doors as the fire exits. The following smoke detectors have been installed so far: 3 smoke detectors in the 2 East Dining Area and 2 in the 3 East Dining area. The corridor outside the 2 East has 4 smoke dectectors and the corridor on 3	08/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	second and third floor West Corridor door sets. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:00 a.m. to 11:50 a.m. on 07/22/11, the second and third floor dining room Center Stairwell access door sets and the second and third floor West Corridor door sets in the fire barrier separating health care from assisted living each did not display the one and one half hour rating required for a door in a two hour fire wall. Based on interview at the time of observation, the Maintenance Manager acknowledged no fire protection rating was listed on each door and they did not have any documentation of the fire protection rating for each door. This deficiency was cited on 05/23/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		East has 4 smoke Detectors in the corridor. All of these smoke dectectors are connected to the Fire Panel.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 2 dining rooms' corridor doors were provided with positive latching hardware. This deficient practice could affect any resident staff or visitor in the vicinity of the second floor dining room and the third floor dining room. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:00 a.m. to 11:50 a.m. on 07/22/11, the second floor dining room has two sets of corridor doors and the third floor dining room has one corridor door set. Each door set is equipped with roller latches at the top of each door but each door set lacked a positive latching mechanism. Based on interview at the	K0018	We consulted with Beth A. Alexander from FP&C Consultants at 486-5188 who explained that since we were putting smoke detectors in every room in the home that the doors are not connected with Fire Barrier.	08/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	time of observation, the Maintenance Manager acknowledged each dining room door set was not provided with positive latching hardware. This deficiency was cited on 05/23/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 4 of 4 door sets in the fire barrier separating health care from the assisted living occupancy are equipped with positive latching to provide the protection needed for a two hour fire barrier. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4. LSC 7.2.4.3.4 requires any opening in fire barriers be protected as provided in 8.2.3. LSC 8.2.3.2.1 requires fire doors to be installed in accordance with NFPA 80. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is	K0044	We are putting in smoke dectectors in every room in the home thus expanding the facility. After consultation with Beth Alexander and Mr. Dean Illingworth it is our understanding that their is no separation of the nursing from the residential.	08/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 01 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	achieved on each door operation. This deficient practice could affect residents, staff and visitors in the vicinity of the second and third floor dining room Center Stairwell access doors and the second and third floor West Corridor door sets. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:00 a.m. to 11:50 a.m. on 07/22/11, the second and third floor dining room Center Stairwell access door sets and the second and third floor West Corridor door sets in the fire barrier separating health care from assisted living each are not provided with a positive latching mechanism. Based on interview at the time of observation, the Maintenance Manager acknowledged each door set was not equipped with a positive latching mechanism. This deficiency was cited on 05/23/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			